EXHIBIT 2
DATE 4.1.15
SB 316

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Office of Legal Affairs ♦ PO Box 4210, 111 N. Sanders ♦ Helena, MT 59604-4210
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Steve Bullock, Governor

Richard H. Opper, Director

Summary of Testimony and Supporting Materials Department of Public Health and Human Services In Opposition to Senate Bill No. 316 Before the House Human Services Committee March 27, 2015 - 3:00 p.m.

The Department of Public Health and Human Services strongly opposes this bill because:

I. It creates a hearing process for transfer of felony inmates from a health care facility to prison that increases the risk of harm to patients and staff by disgruntled inmates in an already high-risk environment;

II. It deprives the Director of the close contact and advice he or she needs from highly experienced clinical professionals who are best qualified to assess the custody, care and treatment needs of GBMI inmates at DPHHS facilities, and substitutes a legalistic hearing process;

III. It permits unqualified correctional personnel to override clinical professionals and the DPHHS director and force a GBMI prisoner to be transferred back to a health care setting with no process at all.

IV. The proposed hearing process is unnecessary, unwieldy and seems designed to create maximum confusion.

A. The existing statutory transfer process is legal, fair, thoughtful and relatively quick, which is vital for the safety of others.

B. The hearing procedure in the bill is inconsistent with MAPA and creates significant confusion.

V. It requires unfunded expenditures for hearing officers, attorneys, and evaluators that are not legally required for a transfer to prison of a convicted felon who has already been deprived of liberty by a court;

VI. It requires unfunded expenditures for mental health services duplicating existing prison mental health services.

DPHHS urges the committee to table or give SB 316 a "do not pass" recommendation.

Myths About SB 316

1. MYTH: Inmates are transferred from MSH to solitary confinement in prison
TRUTH: These are not disciplinary transfers. When a GBMI inmate is transferred, he or she is placed in the general population, in either the MSP Martz Diagnostic Center or the MWP Intake Unit (with the possible exception of acutely violent inmates). The prisoner's subsequent housing placement depends on the prison classification and discipline system, and is based entirely on the prisoner's behavior. At this time, of 23 GBMIs in Montana prisons:

   - More than half are in low or medium custody status
   - Many hold jobs.
   - Three are in close custody status, two in maximum custody status
   - Three of those in close or maximum status are in locked housing units
   - NONE are in isolation cells

2. MYTH: Montana State Prison uses long term solitary confinement to punish inmates for symptoms of mental illness.
TRUTH: Under DOC policies, disciplinary segregation is only imposed after a mental health professional finds that the inmate's behavior is NOT the result of mental illness. Any isolation of an inmate with unsafe mental illness-related behavior is for the sole purpose of protecting the inmate from harming self or others during a period of imminent danger.

3. MYTH: There is no treatment for inmates with mental health problems at Montana's state prisons.

   TRUTH: All Montana prisons offer physical and mental health services. MSP has a 12-bed mental health cell block. MSP health services, including mental health services, are fully accredited by the National Commission on Correctional Health Care, most recently in 2014.

4. MYTH: Montana has no "not guilty" category for persons with serious mental illness.

TRUTH: 46-14-301 provides just such a category. There are currently eight "not guilty" defendants placed at MSH, and two at the Montana Mental Health Nursing Care Center.

5. MYTH: GBMI inmates are non-violent mentally ill or developmentally disabled individuals who had a "brush with the law" and were misdirected into the criminal justice system instead of the mental health system.

   TRUTH: All GBMI inmates have received full constitutional due process in Montana's district courts, and have been found guilty of serious felony crimes. The 22 GBMIs currently serving their sentences in Montana prisons have been judged criminally responsible for:

   - 11 Homicides
   - 7 Attempted homicides, felony assaults, and criminal endangerments
   - 10 Felony sex crimes (5 are designated as Level 3 Sex offenders)
   - 11 Felony Property crimes (criminal mischief, arson, theft, robbery, burglary)

   Their sentences range from 5 years to 180 years.

6. MYTH: GBMI transfer to prison is a one-way street. No one ever comes back to MSH.

   TRUTH: The DPHHS director has full authority to transfer a GBMI inmate back to the hospital. Currently, MSH is treating 3 GBMI inmates who were previously transferred to prison, as well as 3 non-GBMI prison inmates who were civilly committed to MSH for hospital-level care of mental illnesses.

7. MYTH: GBMI inmates have a constitutional right to a due process hearing before being transferred to the general population of a prison.

   TRUTH: No court in the United States has found such a right when the inmate has been convicted by a court and sentenced to the custody of the state with correctional facility placement authority. Last year, the Montana U.S. District Court dismissed a complaint filed by Disability Rights Montana, asserting such a right.

8. MYTH: MSH staff and the DPHHS director transfer GBMI inmates to prison arbitrarily, without considering their custody, care and treatment needs.

TRUTH: Each GBMI inmate at MSH is reviewed periodically by the MSH Forensic Review Board, a panel of professionals not directly involved with the inmate's care. The main job of the FRB is to grant privileges and authorize placement in less-restrictive settings; it only occasionally recommends transfer to correctional facilities. A recommendation for transfer begins with the inmate's treatment team, which includes the hospital's board-certified forensic psychiatrist. Under an MOU with the Department of Corrections, a representative from the proposed correctional facility attends any FRB meeting on a transfer, to assess whether the facility can meet the inmate's mental health and other needs. The FRB thoroughly discusses the proposed transfer prior to reaching its conclusion, and if it concurs with the treatment team it sends a multi-page report to the director, detailing the inmate's history, evaluations, hospital course, and explaining why the inmate no longer needs and/or cannot be safely maintained in a hospital or group home environment. The DPHHS director carefully reviews the report, and uses sound judgment to determine whether a correctional facility will better meet the inmate's custody, care and treatment needs.

Montana GBMI Offenders, Statistics At-A-Glance
As of March 27, 2015

130 total GBMI offenders with unexpired sentences

- 53 GBMI offenders on probation or parole
- 64 GBMI inmates at health care facilities
  - 45 Montana State Hospital
    - 23 Locked Forensic Unit (D-Unit)
    - 21 Group Homes
  - 8 Montana Developmental Center
    - 0 Locked Unit (ASU)
    - 8 Cottages
  - 1 Montana Mental Health Nursing Care Center
- 23 GBMI inmates currently in correctional facilities
  - 15 Montana State Prison
  - 4 Montana Women's Prison
  - 4 Crossroads

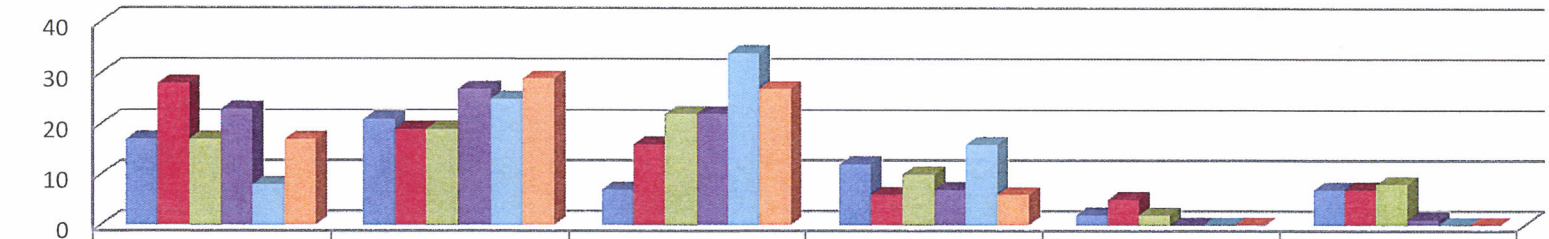
Crimes of which transferred inmates were convicted:

- 11 Homicides
- 7 Attempted homicides, felony assaults, and criminal endangerments
- 10 Felony sex crimes (5 prisoners designated as Level 3 Sex offenders)
- 11 Felony Property crimes (criminal mischief, arson, theft, robbery, burglary)

Sentences range from 5 years to 180 years.

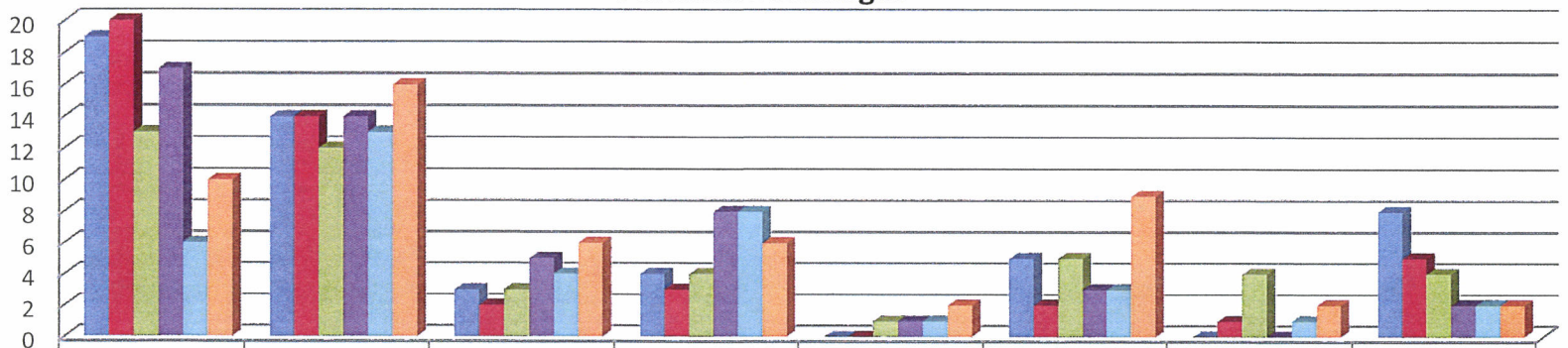
3 GBMI inmates transferred to correctional facilities each year (past 5 years average, MSH and MDC together)

Forensic Commitments 2009 - 2014



	COE: Fitness Evaluation	UTP: Fitness Restoration	PSE: Pre-sentence Evaluation	GBMI: Guilty But Mentally Ill	NGMI: Not Guilty - Mentally Ill	IIT: 10 Day Inter-institutional Transfer
2009	17	21	7	12	2	7
2010	28	19	16	6	5	7
2011	17	19	22	10	2	8
2012	23	27	22	7	0	1
2013	8	25	34	16	0	0
2014	17	29	27	6	0	0

Forensic Discharges



	Eval Complete/Rtn County	Fitness Restored/Rtn County	UTP foreseable future/Civil Commitment	UTP foreseable future/ No Civil Commitment	Dsch GBMI Sentence	Granted Parole on GBMI Sentence	Court approved Conditional Release	DPHHS Director Transfer to DOC
2009	19	14	3	4	0	5	0	8
2010	20	14	2	3	0	2	1	5
2011	13	12	3	4	1	5	4	4
2012	17	14	5	8	1	3	0	2
2013	6	13	4	8	1	3	1	2
2014	10	16	6	6	2	9	2	2

Case Law on Due Process for Inter-Institutional Transfer of Convicted Inmates Serving Sentences

1. The U.S. Supreme Court recognizes that:

   "[t]ransfers between institutions, for example, are made for a variety of reasons and often involve no more than informed predictions as to what would best serve institutional security or the safety and welfare of the inmate."

Meachum v. Fano, 427 U.S. 215, 225 (1976).

2. It also holds that the U.S. Constitution does not require due process unless a change in confinement "imposes atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life," *Sandin v. Conner*, 515 U.S. 472, 484 (1995).

3. The 9th Circuit holds that:

   "[a]s long as the conditions or degree of confinement to which the prisoner is subjected is within the sentence imposed upon him and is not otherwise violative of the Constitution, the Due Process Clause does not in itself subject an inmate's treatment by prison authorities to judicial oversight."

   Chappell v. Mandeville, 706 F.3d 1052, 1062 (9th Cir. 2013).

4. The Montana Supreme Court has recognizes that the authority to place a sentenced offender is within the discretion of the DOC under 46-18-201(3)(a)(iv)(A) "in an appropriate correctional facility or program." *Keierleber v. Mahoney*, 2007 Mont. LEXIS 712, 3 (Mont. Dec. 19, 2007)

5. The only situation where a federal court has imposed a due process requirement is when an ordinary prison inmate is transferred FROM a prison TO a psychiatric hospital, and then only when the transfer is "is not within the range of conditions of confinement to which a prison sentence subjects an individual," *Vitek v Jones*, 445 U.S. 480(1980).

MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

FORENSIC REVIEW BOARD

Effective Date: February 28, 2011 **Policy #:** FP-01

I. PURPOSE:

A. To define the structure and function of the Forensic Review Board.

II. POLICY:

A. Montana State Hospital will have a Forensic Review Board responsible for providing a clinical and administrative review of treatment team recommendations for the following.
   1. Privileges to attend activities on the hospital grounds without staff escorts.
   2. Campus pass on the hospital grounds.
   3. Privileges to attend activities (other than medical appointments/procedures or court hearings) off the hospital grounds.
   4. Placement in other mental health programs or facilities.
   5. Placement in Department of Corrections programs or facilities.
   6. Discharge to the community.
   7. Other actions as requested by the patient's treatment team, the Medical Director, or the Hospital Administrator.

B. The Board will be comprised of five members:
   Hospital Administrator (Chair)
   Medical Director
   Director of Nursing
   Two other members of the Hospital's clinical staff appointed by the Administrator

III. DEFINITIONS:

A. Forensic Patient – A patient at the Hospital due to their involvement with the criminal justice system. Generally, these patients are on one of the following types of commitment – Court Ordered Evaluation (COE), Unfit to Proceed (UTP), Not Guilty by Reason of Mental Illness (NGMI), Guilty but Mentally Ill (GBMI). Also may include patients on civil commitments transferred from Montana Department of Corrections facilities, and may include patients on civil commitments who are known to have committed serious criminal acts.

B. Treatment Team – The Treatment Team responsible for the Forensic Patient's care.

C. Division – The Addictive and Mental Disorders Division of the Department of Public Health and Human Services (AMDD)

D. Department – The Department of Public Health and Human Services (DPHHS)

E. Administrator – The Administrator of the Addictive and Mental Disorders Division (AMDD)

F. Director – The Director of DPHHS

G. Board – The Forensic Review Board (FRB)

IV. RESPONSIBILITIES:

A. The Forensic Review Board is responsible for reviewing and voting on Treatment Team recommendations regarding privileges and placement of Forensic Patients.

B. Hospital Administrator or designee – Is responsible for scheduling and chairing Forensic Review Board meetings. Also responsible for reviewing, approving, and forwarding FRB recommendations to the treating physician, Administrator, and Director or others as required.

C. Medical Director – Is responsible for chairing FRB meetings in the Hospital Administrator's absence.

D. Board Members – Will contribute time and effort to help assure that the committee remains active, well informed, and responsive to the hospital and forensic team. Each member is expected to attend and participate in Board meetings.

V. PROCEDURE:

A. **To request approval for an increase in privileges for a Forensic Patient:**

1. The attending psychiatrist or other licensed prescriber will prepare a report to the committee describing the patient's history, hospital course, and action requested. The following topics should be addressed to the extent that they are relevant to a specific case:
   a. Pertinent background
   b. Psychiatric history
   c. Criminal history
   d. Current charges/conviction including a description of the crime that resulted in placement at MSH

e. County of commitment
f. Type of commitment including length of sentence and rationale for placement at MSH
g. Diagnosis and summary of evaluation/assessment findings
h. Current treatment goals and objectives
i. Treatment interventions identified on the patient's treatment plan and planned treatment if increased privileges are approved by the Forensic Review Board
j. Expected discharge date and discharge plan to the extent that one has been developed
k. Description of the patient's involvement in treatment and response
l. Summary of the victim's perspective including potential impact of the proposed action on the victims, if relevant
m. Recommendation to be considered by the Forensic Review Board

2. Upon receipt of the report, the Hospital Administrator will schedule a Meeting of the Board. Meetings will normally be scheduled for a regular day and time, but may be changed as needed. The Hospital Administrator will provide copies of the written report to members of the Board in advance of the meeting.

3. The attending psychiatrist/licensed prescriber and/or other staff will make an oral presentation to the Board. A format for the presentation is provided in Attachment A.

4. The Board will hear the presentation, interview the patient (if desired), discuss the case, and then vote.

5. Following the vote, the patient's attending Licensed Independent Practitioner (LIP) will ensure that the FRB decision is conveyed to the patient in a timely manner (unless contraindicated).

6. The Forensic Review Board may seek a legal opinion any time it is determined to be necessary or advisable. The Chair may suspend, delay and reschedule proceedings as a result of this action.

7. The Treatment Team will prepare a final report that includes the information presented to the Forensic Review Board and a summary of the presentation and the Board's action, in the format indicated in Attachment A. This report will be signed by Treatment Team members, the Medical Director, and the Hospital Administrator or designee.

B. **In the case of recommendation for discharge or alternative placement –**

1. The treating psychiatrist or other licensed prescriber may ask to convene the meeting without notice to the patient when doing so could compromise safety or security of the facility or any person.

2. The Chairperson will submit all recommendations to the DPHHS Attorney who will advise the Director of the Department of Public Health and Human Services. The DPHHS Attorney will file petitions or other documents with District Court when required.

3. When a recommendation for transfer to a correctional facility is made, the patient need not be notified of the Board's action until the time of transfer in order to avoid possible compromise of safety or security that could result.

4. A forensic patient may be transferred to a correctional facility on an emergency basis with approval of the DPHHS and DOC Directors. In such an instance, a Forensic Review Board meeting will review the transfer after it has taken place.

C. **Forensic Review Board Procedure**

1. When a regular member of the Forensic Review Board is not available for a meeting, the Chair may request another employee to participate on the Board.

2. Members of the presenting treatment team may participate in the discussion, but may not vote.

3. Advocates or other parties requested by the patient may attend the meeting and address the board. However, they may not vote on the recommended action.

4. Voting Quorum - A minimum of five (5) members of the Forensic Review Board must be present in order for the Board to take action on a recommendation.

5. Students and other parties may observe Forensic Review Board meetings if approved by the patient and by the Chair.

D. **Hospital Administrator Approval**

The Board's recommendations do not become final until the Hospital Administrator or designee grants approval. The administrator may turn down or modify the Board's recommendations.

VI. **REFERENCES:** Patterson and Wise, "The Development of Internal Forensic Review Boards in the Management of Hospitalized Insanity Acquitees," J AM Acad Psychiatric Law, Vol. 26, No 44, 1998.

VII. **COLLABORATED WITH:** Hospital Administrator, Medical Director, Forensic Program Psychiatrist

VIII. RESCISSIONS: Policy #FP-01, *Forensic Review Board*, dated May 19, 2010; Policy #FP-01, *Forensic Review Board*, dated January 14, 2008; Policy #FP-01, *Forensic Review Board*, dated March 28, 2002; Policy #FP-01, *Forensic Review Board*, dated March 21, 2000.

IX. DISTRIBUTION: All hospital policy manuals.

X. REVIEW AND REISSUE DATE: February 2014

XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XI. ATTACHMENTS:

Attachment A – FRB Report Format
Attachment C – FRB Request Report

_____	___/___/___	_____	___/___/___
John W. Glueckert Hospital Administrator	Date	Thomas Gray, M.D. Medical Director	Date

MONTANA STATE HOSPITAL
Forensic Review Board Report
Date

Name:
MSH #:
Court Cause #:
Date of Presentation:
Location:
Reason for Presentation:
Forensic Review Board Members Present:
Forensic Review Board Members Present:

A. Identifying Data

B. Pertinent Historical Information

C. Hospital Course

D. Interview (If Needed)

E. Medications

F. Diagnoses
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

G. Signatures of Forensic Program Treatment Team

H. Conclusions and Recommendations of the Forensic Review Board

I. Signatures of Forensic Program Treatment Team

FORENSIC REVIEW BOARD
Request Report
Proposed Presentation

1.	Demographics:	
2.	FRB Date:	
3.	MSH #:	
4.	Court Cause #:	
5.	Commitment Type:	
6.	Admission Date:	
7.	Location:	
8.	Reason for Presentation:	
9.	Diagnoses:	
10.	Crime:	
11.	Crime Circumstances:	
12.	Jail Behavior:	
13.	Psychiatric History:	
14.	Drug/Alcohol History:	
15.	Family History:	
16.	Medical History:	
17.	Social History:	
18.	Work History:	
19.	Marital History/Children:	
20.	Military Service:	
21.	Criminal History:	
22.	Overall Hospital Course:	
23.	Self-Care:	
24.	Socialization:	
25.	Incidents:	
26.	Response to Staff Direction:	
27.	Medications:	
28.	Groups:	
29.	Family Contact:	
30.	Insight:	
31.	Victim Perspective:	

HJR 16: State-Operated Institutions
Transfers Between MSH and MSP

Prepared by Sue O'Connell, Research Analyst
for the Children, Families, Health, and Human Services Interim Committee
November 2013

Background

Under 46-14-312, MCA, individuals convicted of a crime may be sentenced to the custody of the director of the Department of Public Health and Human Services (DPHHS) if they have been found to have "a mental disease or defect" that prevented them from appreciating the criminality of their conduct or from following the requirements of the law. The director determines a person's appropriate placement in a correctional, mental health, or developmental disabilities facility and may later transfer the person to another facility to better meet "custody, care, and treatment needs." Both the initial placement and any transfer must be based on recommendations made by professionals evaluating or treating the individual.

In addition, 53-21-130, MCA, allows DPHHS or the Department of Corrections to transfer a person in their custody to the Montana State Hospital (MSH) for up to 10 days if the person needs the intensive mental health treatment offered there.

After hearing about transfers made under these laws during visits to MSH and the Montana State Prison (MSP) in September, the Children, Families, Health, and Human Services Interim Committee asked for more detailed information on the number of transfers that have occurred between the two facilities and the frequency with which a person transferred to MSP is transferred back to the State Hospital because his mental illness has worsened.

This briefing paper summarizes information provided by the facilities in response to the request. The information covers the past five fiscal years, from July 1, 2008, through June 30, 2013.

Transfers from MSH to MSP

MSH may transfer to a correctional facility only those patients who have been convicted of a crime and found to be guilty but mentally ill (GBMI). MSH may not send to the prison any Forensic Unit patients who are undergoing pre-trial or pre-sentence evaluations or who are receiving treatment so they will be fit to proceed with a trial.

During the five-year period, MSH transferred 22 patients to the Montana State Prison and two patients to the Montana Women's Prison. MSH officials say these guilty but mentally ill (GBMI) patients are generally transferred because:

- their dangerous behaviors prevent them from being safely managed at MSH regardless of their mental status; or
- the symptoms of their mental illness are mild or in remission and they are not benefitting from the hospital level of care. In this case, an offender usually isn't participating in treatment activities or is disrupting the treatment of other MSH patients.

Although the DPHHS director ultimately determines whether to transfer a GBMI patient, most transfers are based on a recommendation by a treatment team. The recommendations are reviewed by the hospital's Forensic Review Board, the MSH administrator, and DPHHS legal counsel before the director authorizes a transfer. The treatment staff takes into account numerous clinical factors before recommending a transfer. The DPHHS director and the Department of Corrections director may approve an emergency transfer without prior review by the board if an emergency situation exists because of dangerous behavior.

Transfers from MSP to MSH

The prison may transfer to MSH any inmate who may need intensive mental health treatment, using the 10-day transfer process, an involuntary commitment process, or the authority of the DPHHS director to transfer GBMI offenders who were sentenced to the director's custody. A person admitted to MSH on a 10-day transfer may not remain longer unless he is voluntarily admitted or the state follows the procedures for an involuntary commitment.

In the past five fiscal years, the prison transferred eight inmates to MSH. Three transfers involved GBMI inmates who had been at MSH previously; two of the three had been at the prison for more than three years before they returned to MSH, while the third had been at the prison for nearly two-and-a-half years. The transfers break down as follows:

- Four non-GBMI inmates were transferred under the 10-day transfer law. Of those, two voluntarily agreed to remain at MSH for additional treatment, one was there for nine days, and one was there for 12 hours.

- One non-GBMI inmate was involuntarily committed in a proceeding initiated by the prison.

- One GBMI inmate was transferred under the 10-day transfer law and was then involuntarily committed in a proceeding initiated by MSH.

- Two GBMI inmates who had been at MSH previously were returned there by the DPHHS director following a Forensic Review Board recommendation.

According to information provided by the prison, the transfers occurred because the individuals were not responding to treatment or medication for their mental disorders, became psychotic and needed intensive treatment, or exhibited suicidal behavior.

Transferring Information Between Facilities

When the prison transfers an inmate from the Mental Health Treatment Unit to MSH, officials provide the hospital with the person's treatment plan. If the offender was in the general population, MSP provides the hospital with the person's mental health file. MSH continues providing services that are comparable to those offered in prison, when comparable services exist. When they don't, the hospital develops its own plan of care for the person.

When a GBMI patient is transferred from MSH to the prison, mental health professionals from the prison are included in the Forensic Review Board meeting to discuss the offender's care and review placement alternatives. The prison follows the treatment plan developed at this time but has the ability to adjust it as needed to benefit the patient.

NEWSRELEASE

Montana Department of Corrections • 5 S. Last Chance Gulch
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FOR IMMEDIATE RELEASE
Tuesday, July 29, 2014

CONTACT: Judy Beck, 444-0409

Montana State Prison health services ace national re-accreditation review
68 standards met and no deficiencies give compliance score of 100 percent

DEER LODGE – State corrections director Mike Batista today announced that the infirmary at the Montana State Prison has been re-accredited for three years. A two-day onsite audit conducted by the National Commission on Correctional Health Care (NCCHC) survey team in May this year found that the medical and mental health care services provided at the men's prison met all of the commission's 68 standards. The audit noted no deficiencies.

"This outstanding audit is a credit to the many dedicated health care professionals who work at the Montana State Prison," Batista said. "Providing high quality care in a secure facility presents some unique challenges, but the prison's clinical team rises above these difficulties on a daily basis and does a tremendous job for the inmates and for Montana taxpayers."

The NCCHC report praised prison staff for working together to ensure that inmates receive the care they need: "We noted excellent cooperation between custody and medical staff. Administrative decisions such as utilization review are coordinated, if necessary, with clinical needs so that patient care is not jeopardized."

The MSP infirmary was accredited for the first time in 2011. Re-accreditation reviews are conducted on a three-year cycle.

"Our re-accreditation demonstrates how committed everyone on the clinical staff has been over the past three years to adhering to each and every NCCHC standard," Connie Winner, administrator of the DOC Clinical Services division said. "We're fortunate that the entire medical and mental health team at the state prison is so motivated and hardworking. I'm very proud of what they have accomplished."

The National Commission on Correctional Health Care is dedicated to improving the quality of health care services and helping correctional facilities provide effective and efficient care. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the

efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

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